

REFERRING DOCTORS

THANK YOU SO MUCH FOR TRUSTING US WITH YOUR PATIENT!

Please send your notes and complete the following information:

Referring Doctor:

Patient Name *

Patient Phone Number *

Date Of Birth (yyyy-mm-dd)

Appointment has been made with Dr.

Date (yyyy-mm-dd)

Time (hh:mm am/pm)

☐ Please call Patient to set Appointment.

Referral Notes

☐ Previously Sent ☐ Sending Today

Referred for (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Dry Eye Evaluation (with Oculus 5M Keratograph and Crystal Tear Report) and necessary testing/ treatment | <input type="checkbox"/> Lipiscan / Lipiflow |
| <input type="checkbox"/> Tear Lab Osmolarity | <input type="checkbox"/> External Neurostimulation |
| <input type="checkbox"/> Inflammadry | <input type="checkbox"/> Prokera Amniotic Membrane |
| <input type="checkbox"/> Punctal Occlusion | <input type="checkbox"/> Autologous Blood Serum |
| <input type="checkbox"/> Blepharoexfoliation: NuLids / BlephEx | <input type="checkbox"/> Scleral Lens Fitting |
| <input type="checkbox"/> Intense Pulsed Light (IPL) | <input type="checkbox"/> Percutaneous Allergy Skin Testing (78 allergens) |

Please return patient after:

- | | |
|--|---|
| <input type="checkbox"/> Dry eye evaluation and report, without treatment | <input type="checkbox"/> Once symptoms have resolved and patient is stable |
| <input type="checkbox"/> Dry eye evaluation, report, and treatment initiation | <input type="checkbox"/> For non-ocular surface issues only (routine exam, retina, glaucoma, etc) |
| <input type="checkbox"/> Treatment indicated above, without evaluation (not recommended) | |

Additional notes:

Fax: 860-747-6880

Email: drdhiggins2020@gmail.com